MISSOURI

DIVISION OF MEDICAL SERVICES

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Physician Bulletin

Due to budget constraints, paper copies of bulletins will no longer be distributed by DMS. Bulletins are now available only at the DMS Website.

Bulletins will remain on this site only until incorporated into the provider manuals as appropriate, then deleted.

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MC+ MANAGED CARE

The information contained in this bulletin applies to coverage by the MC+ fee-for-service and Medicaid fee-for-service programs. The MC+ fee-for-service and Medicaid fee-for-service programs also provide coverage for those services carved out of the MC+ Managed Care benefit for MC+ Managed Care enrollees. Questions regarding services included in the MC+ Managed Care benefit should be directed to the enrollee's MC+ Managed Care health plan. Please check the patient's eligibility status prior to delivering a service.

HIPAA

To prepare for the October 16, 2003 mandatory implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) national standards, Missouri Medicaid has analyzed how providers must bill for services in order to be in compliance with the implementation of national transaction and code sets.

HIPAA mandates the use of standard Health Care Procedure Coding System (HCPCS) code sets; however, it does *not* require states to add coverage for services that it does *not* currently cover.

Billing providers wishing to exchange electronic transactions with Missouri Medicaid may now view the X12N Version 4010A1 Companion Guide on Missouri Medicaid's web page at http://www.medicaid.state.mo.us/ To access the Companion Guide, select Missouri Medicaid Electronic Billing Layout Manuals; select System Manuals; select Electronic Claims Layout Manuals; select X12N Version 4010A1 Companion Guide. For information on Missouri Medicaid's Trading Partner Agreement, select Section 1 - Getting Started; select Trading Partner Registration. All questions concerning Trading Partner Agreements or provider testing schedules should be directed to the Verizon Help Desk at 573-635-3559.

Billing providers wishing to exchange electronic pharmacy transactions with Missouri Medicaid may now view the NCPDP Telecommunication V.5.1 and Batch Transaction Standard V.1.1 Companion Guide on Missouri Medicaid's web page at http://www.medicaid.state.mo.us/ To access the Companion Guide select Missouri Medicaid Electronic Billing Layout Manuals; select Systems Manuals; select Electronic Claims Layout Manuals; select NCPDP Telecommunication V.5.1 and Batch Transaction Standard V.1.1 Companion Guide. For information on Missouri Medicaid's Trading Partner Agreement, select Section 1 - Getting Started; select Trading Partner Registration. All questions concerning Trading Partner Agreements or provider testing schedules should be directed to the Verizon Help Desk at 573-635-3559.

With the implementation of HIPAA national standards by Missouri Medicaid, the following non-HIPAA compliant methods of electronic claims submission will be phased out and will no longer be available for use by providers:

- Accelerated Submission and Processing (ASAP) System
- Bulletin Board System (BBS)
- Direct Electronic File Transfer (DEFT)
- Direct Electronic Medicaid Information (DEMI)
- Magnetic Tape Billing (MTB)

The existing formats and media will be available during a short grace period for providers unable to produce a HIPAA-compliant 837 professional transaction starting October 16, 2003. Providers may continue to bill current Missouri Medicaid formats and media during this grace period.

All providers wishing to bill Missouri Medicaid in paper format should refer to Section 15 – Billing Instructions Physicians for paper claim filing instructions.

TYPE OF SERVICE

With the implementation of HIPAA national standards on October 16, 2003, type of service will no longer be a valid code set. Type of service *must not* be included on any type of claim submission (other than the non-HIPAA compliant formats and media as defined above) on or after October 16, 2003, regardless of the date of service being billed. In order to make up for the loss of type of service, claims submitted to Missouri Medicaid must reflect an appropriate modifier with a procedure code when billing for the services defined below. For example, prior to October 16, 2003, when billing for an assistant surgeon's services, a procedure code is submitted with type of service 8. Effective on or after October 16, 2003, when billing for an assistant surgeon's service, a procedure code must be submitted with modifier '80'. Failure to do so may result in claim denial.

Modifier	Definition
26	Professional Component
54	Surgical Care Only
55	Postoperative Management Only
80	Assistant Surgeon
AA	Anesthesia service performed personally by anesthesiologist
NU	New Equipment (required for DME service)
QK	Medical direction of 2, 3 or 4 concurrent anesthesia procedures involving qualified individuals
QX	CRNA service; with medical direction by a physician
QZ	CRNA service; without medical direction by a physician
RP	Replacement and Repair (required for DME service)
RR	Rental (required for DME service)
SE	State and/or federally funded programs/services
SG	Ambulatory Surgical Center (ASC) facility services
TC	Technical Component
UC	EPSDT Referral for Follow-up Care (required if EPSDT referral made)

Providers who continue to bill claims to Missouri Medicaid using one of the non-HIPAA compliant electronic formats or media during the grace period, as stated under the HIPAA Section of this Bulletin, should continue to bill using the appropriate type of service with the new procedure codes identified in this bulletin.

SAFE/CARE

In order to comply with the HIPAA national standards for transactions and code sets, all Missouri Medicaid-specific procedure codes/modifiers must be replaced. Effective for dates of service on or after October 16, 2003, the procedure codes for Sexual Assault Findings Examination (SAFE), W1350 and Child Abuse Resource Education (CARE), W1350WO will change to Current Procedural Terminology (CPT) codes and their description. Modifier WO will be replaced with modifier ***U7, Sexual Assault Findings Examination (SAFE) and Child Abuse Resources Examination (CARE) Network Services***. For dates of service prior to October 16, 2003, providers should continue to bill using the appropriate Missouri Medicaid-specific procedure codes/modifiers. Please refer to the Physician's Manual, Section 13.15 for policy concerning SAFE/CARE. See the table below for replacement procedure codes and/or modifiers:

Medicaid-Specific Code/Modifier	Replacement Code/Modifier	Description
W1350	99205 U7	Sexual Assault Findings Examination (SAFE)
W1350 WO	99205 U7 52	Child Abuse Resource Education (CARE) Exam
57452 WO	57452 U7	See CPT for description
99170 WO	99170 U7	See CPT for description
81025 WO	81025 U7	See CPT for description
86317 WO	86317 U7	See CPT for description
86592 WO	86592 U7	See CPT for description
86631 WO	86631 U7	See CPT for description
86632 WO	86632 U7	See CPT for description
86687 WO	86687 U7	See CPT for description
86688 WO	86688 U7	See CPT for description
86689 WO	86689 U7	See CPT for description
87110 WO	87110 U7	See CPT for description
87210 WO	87210 U7	See CPT for description
87390 WO	87390 U7	See CPT for description
87391 WO	87391 U7	See CPT for description
87534 WO	87534 U7	See CPT for description
87535 WO	87535 U7	See CPT for description
87536 WO	87536 U7	See CPT for description
87537 WO	87537 U7	See CPT for description
87538 WO	87538 U7	See CPT for description
87539 WO	87539 U7	See CPT for description
86820 WO	86820 U7	See CPT for description
87420 WO	87420 U7	See CPT for description

DIABETES SELF MANAGEMENT TRAINING

In order to comply with the HIPAA national standards for transactions and code sets, all Missouri Medicaid-specific procedure codes/modifiers must be replaced. Effective for dates of service on or after October 16, 2003, the procedure codes for Diabetes Self Management Training will change to Current Procedural Terminology (CPT) and/or Health Care Procedure Coding System (HCPCS) and their descriptions. For dates of service prior to October 16, 2003, providers should continue to bill using the appropriate Missouri Medicaid-specific procedure codes/modifiers. Please refer to the Physician's Manual, Section 13.71 for policy concerning Diabetes Self Management Training.
See the table below for replacement procedure codes and/or modifiers:

Medicaid-Specific Code/Modifier	Replacement Code/Modifier	Description
W0037	99205 U9	Initial Assessment – Comprehensive Diabetes Education – Minimum 1 hour
W0038	G0108	Diabetes Education – subsequent visit – minimum 30 minutes
W0039	G0109	Diabetes Education -Group

CASE MANAGEMENT FOR PREGNANT WOMEN

In order to comply with the HIPAA national standards for transactions and code sets, all Missouri Medicaid-specific procedure codes/modifiers must be replaced. Effective for dates of service on or after October 16, 2003, the procedure codes for Prenatal Case Management will change to Health Care Procedure Coding System (HCPCS) and their description.

For dates of service prior to October 16, 2003, providers should continue to bill using the appropriate Missouri Medicaid-specific procedure codes/modifiers. Please refer to the Physician's Manual, Section 13.66 for policy concerning Case Management. See the table below for replacement procedure codes and/or modifiers:

Medicaid-Specific Code/Modifier and Description	Replacement Code/Modifier	HCPCS Descriptions
X4020 (Risk Appraisal, Pregnant Women)	H1000	Prenatal care, at-risk assessment
X4024 (Month with Initial Visit)	H1001	Prenatal care, at risk enhanced service; antepartum management
X402452 (Case Management for Pregnant Women, Initial Month, Declined Service)	G9012	Other specified case management service not elsewhere classified.
X4022 (Case Management for Pregnant Woman, Month with Face-to-Face Visit)	H1001 TS	Prenatal care, at risk enhanced service; antepartum management; follow-up service
X4026 (Case Management for Pregnant Woman, Month with No Face-to-Face Visit)	H1001 TS 52	Prenatal care, at risk enhanced service; antepartum management; follow-up, reduced service
X4025 (Case Management for Pregnant Woman, Month with Visit to Recipient's Home)	H1004	Prenatal care, at risk enhanced service; follow-up home visit

PODIATRY TECHNICAL/PROFESSIONAL

In order to comply with the HIPAA national standards for transactions and code sets, all Missouri Medicaid-specific procedure codes/modifiers must be replaced. Effective for dates of service on or after October 16, 2003, modifier W7-professional component and modifier W8-technical component for Podiatry procedures will no longer be valid. Modifier 26-professional component and modifier TC-technical component will replace modifier W7 and modifier W8. For dates of service prior to October 16, 2003, providers should continue to bill using the appropriate Missouri Medicaid-specific procedure codes/modifiers. Refer to the Physician's Manual, Section 13.73 for policy concerning Podiatry.

Medicaid-Specific Code/Modifier	Replacement Code/Modifier
73620 W7	73620 26
73620 W8	73620 TC
73630 W7	73630 26
73630 W8	73630 TC
73650 W7	73650 26
73650 W8	73650 TC
73660 W7	73660 26
73660 W8	73660 TC

PODIATRY OUTPATIENT VISITS

In order to comply with the HIPAA national standards for transactions and code sets, all Missouri Medicaid-specific procedure codes/modifiers must be replaced. Effective for dates of service on or after October 16, 2003, modifier W2-outpatient setting for podiatry will no longer be valid with E & M procedure codes. The E & M procedure code may be billed without a modifier. For dates of service prior to October 16, 2003, providers should continue to bill using the appropriate Missouri Medicaid-specific procedure codes/modifiers. Refer to the Physician's Manual, Section 13.73 for policy concerning Podiatry. See the table below for replacement procedure codes and/or modifiers: For descriptions of the replacement procedure codes, please reference the CPT coding book.

Medicaid-Specific Code/Modifier	Replacement Code
99201 W2	99201
99202 W2	99202
99203 W2	99203
99204 W2	99204
99205 W2	99205
99211 W2	99111
99212 W2	99212
99213 W2	99213
99214 W2	99214
99215 W2	99215

MOBILE X-RAY

In order to comply with the HIPAA national standards for transactions and code sets, all Missouri Medicaid-specific procedure codes/modifiers must be replaced. Effective for dates of service on or after October 16, 2003, procedure code W4091 for Mobile X-Ray, trip fee, will no longer be valid. HCPCS Code R0070 will replace W4091. For dates of service prior to October 16, 2003, providers should continue to bill using the appropriate Missouri Medicaid-specific procedure codes/modifiers. For policy concerning Mobile X-ray, please refer to Physician's Manual, Section 13.47F. Please refer to the table below:

Medicaid-Specific Code/Modifier	Replacement Code	Description
W4091 Mobile X-Ray, trip fee	R0070	Transportation of portable x-ray equipment and personnel to home or nursing home, per trip to facility or location; one patient seen

INPATIENT NEWBORN CARE

In order to comply with the HIPAA national standards for transactions and code sets, all Missouri Medicaid-specific procedure codes/modifiers must be replaced. Effective for dates of service on or after October 16, 2003, modifier 99 will no longer be valid for procedure codes 99231-99233 for Inpatient Newborn Care. Modifier 63-procedure performed on infants, will replace modifier 99. For dates of service prior to October 16, 2003, providers should continue to bill using the appropriate Missouri Medicaid-specific procedure codes/modifiers. These procedure codes are limited to services provided to newborn/infants for specific diagnosis codes (038.0-038.9, 765.00-765.07, 765.10-765.17, 769, 773.0-773.5, and 775.6). Please refer to table below.

Medicaid-Specific Code/Modifier	Replacement Code/Modifier
99231 99	99231 63
99232 99	99232 63
99233 99	99232 63

AIRCAST

In order to comply with the HIPAA national standards for transactions and code sets, all Missouri Medicaid-specific procedure codes/modifiers must be replaced. Effective for dates of service on or after October 16, 2003, modifier YA will no longer be valid for air casts. Procedure code 99070, miscellaneous supply code, will replace A4580 YA. For dates of service prior to October 16, 2003, providers should continue to bill using the appropriate Missouri Medicaid-specific procedure codes/modifiers. Please refer to table below.

Medicaid-Specific Code/Modifier	Replacement Code
A4580 YA	99070

YG MODIFIER CHANGE

In order to comply with the HIPAA national standards for transactions and code sets, all Missouri Medicaid-specific procedure codes/modifiers must be replaced. Effective for dates of service on or after October 16, 2003, modifier YG for the EPSDT program will no longer be valid. Modifier EP will replace modifier YG. For dates of service prior to October 16, 2003, providers should continue to bill using the appropriate Missouri Medicaid-specific procedure codes/modifiers. Please refer to the table below.

Medicaid-Specific Code/Modifier	Replacement Code/Modifier
11920 YG	11920 EP
11921 YG	11921 EP
11922 YG	11922 EP
17999 YG	17999 EP
21175 YG	21175 EP
21188 YG	21188 EP
44955 YG	44955 EP
69949 YG	69949 EP
92311 YG	92311 EP
92312 YG	92312 EP
92391 YG	92391 EP
92396 YG	92396 EP
94760 YG	94760 EP
94761 YG	94761 EP
94762 YG	94762 EP
99199 YG	99199 EP
99201 YG	99201 EP
99202 YG	99202 EP
99203 YG	99203 EP
99204 YG	99204 EP
99205 YG	99205 EP
99211 YG	99211 EP
99212 YG	99212 EP
99213 YG	99213 EP
99214 YG	99214 EP
99215 YG	99215 EP
A4627 YG	A4627 EP

THIRD OPINION CONFIRMATORY CONSULTANTS

In order to comply with the HIPAA national standards for transactions and code sets, all Missouri Medicaid-specific procedure codes/modifiers must be replaced. Effective for dates of service on or after October 16, 2003, modifier ZZ-third opinion for consultations will no longer be valid. The procedure must be billed without a modifier. For dates of service prior to October 16, 2003, providers should continue to bill using the appropriate Missouri Medicaid-specific procedure codes/modifiers. Please refer to the table below.

Medicaid-Specific Code/Modifier	Replacement Code
99271 ZZ	99271
99272 ZZ	99272
99273 ZZ	99273
99274 ZZ	99274

ADULT PHYSICALS

In order to comply with the HIPAA national standards for transactions and code sets, all Missouri Medicaid-specific procedure codes/modifiers must be replaced. Effective for dates of service on or after October 16, 2003, adult physicals, including a well woman exam (ages 21 and older) will be billed using the appropriate preventive medicine procedure codes 99385 – 99387 and 99395 – 99387. Diagnosis Codes V70.0, "Routine general medical examination at a health care facility," or V73.2, "Gynecological examination" should be used. Medicaid covers one adult "preventive" examination/physical per 12 months. Physicals are also covered when required as a condition of employment. For dates of service prior to October 16, 2003, providers should continue to bill using the appropriate office/outpatient visit procedure codes (99201-99215).

ANESTHESIA SERVICES

In order to comply with the HIPAA national standards for transactions and code sets, all Missouri Medicaid-specific procedure codes/modifiers must be replaced. Effective for dates of service on or after October 16, 2003, anesthesia will be billed using the appropriate CPT anesthesia procedure codes (00100 – 01999). Missouri Medicaid will require the following modifiers when billing for anesthesia services:

- AA - Anesthesia services performed personally by anesthesiologist
- QK - Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals
- QX - CRNA service; with medical direction by a physician
- QZ - CRNA service; without medical direction by a physician

The procedure for which anesthesia is billed must be a covered service. The provider of anesthesia services will be required to ensure the procedure is a covered service. The Missouri's Medicaid Program Integrity Unit will closely monitor claims for anesthesia services. For dates of service prior to October 16, 2003, providers should continue to bill using the appropriate surgical procedure code.

MATERNITY CARE

In order to comply with the HIPAA national standards for transactions and code sets, all Missouri Medicaid-specific procedure codes/modifiers must be replaced. Effective October 16, 2003, procedure code Y9603, global prenatal care, will no longer be valid. For dates of service prior to October 16, 2003, providers should continue to bill using the appropriate Missouri Medicaid-specific

procedure code, Y9603. Missouri Medicaid will begin using the appropriate Maternity Care and Delivery CPT codes as dictated by the national HIPAA standards.

Global prenatal care includes all prenatal visits performed at medically appropriate intervals up to the date of delivery, routine urinalysis testing during the prenatal period, care for pregnancy-related conditions; e.g., nausea, vomiting, cystitis, vaginitis and a "Risk Appraisal for Pregnant Women". Only one prenatal care code, 59425 (4-6 visits) and 59426 (7 or more visits) may be billed per pregnancy. The date of the delivery is the date of service to be used when billing the global prenatal codes. If a provider does more than 3 visits but the recipient goes to another provider for the rest of her pregnancy, all visits must be billed using the appropriate office visit procedure codes.

The global prenatal/delivery/postpartum fee is reimbursable when one physician or physician group practice provides all of the patient's obstetric care. For this purpose, a physician group is defined as an obstetric clinic, provider type "50", there is one patient medical record, and each physician/nurse practitioner/nurse midwife seeing that patient has access to the same patient record and makes entries into the record as they occur. A primary care physician is responsible for overseeing patient care during the patient's pregnancy, delivery and postpartum care. The clinic may elect to bill globally for all prenatal, delivery and postpartum care services provided within the clinic, using the primary care physician's provider number as the performing provider.

Refer to Physician's Manual Section 13.67.

The chart below reflects changes and reimbursement amounts (please reference CPT for descriptions): Given the fact that the Medicaid specific prenatal code, Y9603, which required 5 or more visits, falls within the new HIPAA specific procedure code, 59425, for 4 to 6 visits, the pricing for HIPAA specific procedure codes 59425 (4-6 visits) and 59426 (7 or more visits) will remain the same as Y9603.

Procedure Code	Reimbursement Amount
59425	$525.00
59426	$525.00
59430	$110.00
59400	$1075.00
59409	$440.00
59410	$550.00
59510	$1125.00
59514	$480.00
59515	$600.00
59610	$1075.00
59612	$440.00
59614	$550.00
59618	$1125.00
59620	$480.00
59622	$600.00

DIALYSIS AND HEMODIALYSIS SERVICES IN THE HOME

In order to comply with the HIPAA national standards for transactions and code sets, all Missouri Medicaid-specific procedure codes/modifiers must be replaced. Effective October 16, 2003, the WR (home service) modifier will no longer be valid. For dates of service on or after October 16, 2003, providers must use the modifier U8 with procedure code 90935 and 90945. For dates of service prior to October 16, 2003, providers should continue to bill using the Missouri Medicaid-specific modifier, W4.

DISEASE MANAGEMENT PROGRAM

The Disease Management program targets fee-for service recipients who have a diagnosis of Asthma, Diabetes, Heart Failure or Depression. The assessment types and procedure codes that Physicians and or Pharmacist enrolled in the Disease Management Program may bill are as follows:

Service Type	Procedure Frequency	Procedure Code	Procedure Rate
Initial Assessment	One per Patient	S0315	$75.00
Problem Follow-Up Assessment	Four per patient per 12 months	S0316TS	$40.00
New Problem Assessment	Two per patient per 12 months	S0316	$40.00
Preventative Follow-up Assessment	One per patient per 12 months	S0315TS	$25.00

Information regarding this program may be accessed at the Pharmacy Program Website: www.heritage-info.com/mocaidrx

Provider Communications

(800) 392-0938
or
(573) 751-2896